



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: INTEGRA SPECIALTY GROUP PA 517 N CARRIER PARKWAY SUITE G GRAND PRAIRIE, TX 75050	MFDR Tracking #: M4-09-5826-01 (Previous Tracking #: M4-08-0402-01)
	DWC Claim #:
	Injured Employee:
	Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: EMPLOYERS INSURANCE CO OF WAUSAU Box #: 01	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "...the carrier has failed to provide any proof or records stating that the provider, Integra Specialty Group, was not treating the compensable body area. The pre-authorization was for pain in the low back and the diagnosis code on the billed HCFAs was 724.4 (Lumbago). Therefore, Integra Specialty Group did treat the compensable area during the pre-authorized pain program. ...this claimant's claim is job related, the injury was properly diagnosed, the claimant received the appropriate relevant treatments from the HCP, and the carrier does not dispute the claimant's work injury."

Amount in Dispute: \$28,096.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Charges for the work hardening and chronic pain management programs were denied as not related to the compensable injury. A copy of the PLN-11 form is attached."

Response Submitted by: Carol Crewey, Liberty Mutual, 2875 Browns Bridge Road, Gainesville, GA 30503

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/03/06 – 10/18/06	97545-WH	\$64.00 x 80% (Non-CARF) = \$51.20 (MAR) x 2 hrs. (1 Unit) x 10 DOS	\$1,024.00	\$1,024.00
10/03/06 – 10/18/06	97546-WH	\$64.00 x 80% (Non-CARF) = \$51.20 (MAR) x 6 hrs. x 10 DOS	\$3,072.00	\$3,072.00
11/28/06 – 4/13/07	97799-CP	\$125.00 x 80% (Non-CARF) = \$100.00 (MAR) x 8 hrs. x 30 DOS	\$24,000.00	\$24,000.00
			Total Due:	\$28,096.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §124.2 sets out the carrier reporting and notification requirements.
3. 28 Tex. Admin. Code §133.210 sets out the requirements for medical documentation.
4. 28 Tex. Admin. Code §134.202 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after August 1, 2003.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 50 X591 – Per independent medical exam, no further treatment is necessary. (X591)
- W1 Z343 – Work Hardening. (Z343)
- W10 Z436 – Chronic Pain Management. (Z436)
- W12 X206 – The service(s) is for a condition(s) which is not related to the covered work related injury.
- 50 X375 – Unnecessary medical treatment or service. (X375)
- W11 X597 – This is not an accepted workers' comp claim. (X597)
- W4 X598 – Claim has been re-evaluated based on additional documentation submitted. No additional payment due. (X598)
- W1 X204 – Routine progress/final reports filed by the attending physician do not command a fee. (X204)
- B7 Z121 – Level II certified provider. (Z121)

Issues

1. Did the respondent file a PLN-11 to the Division disputing extent-of-injury?
2. Does this claim have unresolved extent-of-injury issues?
3. Does the submitted documentation support the services billed under CPT codes 97545-WH, 97546-WH, and 97799-CP?
4. Is the requestor entitled to reimbursement?

Findings

1. The respondent originally denied services as, "Per independent medical exam, no further treatment is necessary." However, upon reconsideration, services were denied as, "The service(s) is for a condition not related to the covered work related injury." The respondent did not maintain their denial of not medically necessary upon reconsideration and will not be addressed. The respondent filed a PLN11 on August 3, 2006 stating, "...Per IME/Peer Review dated (7/13/05) by (Dr. Bruce Whitehead), there is no medical documentation to support ongoing medical treatment for the compensable (Lumbar, rt arm) injury of 11/20/04." A PLN11 dated January 5, 2005 disputes the entitlement of TIBS. The Division finds no other PLN11 disputing extent-of-injury. Pursuant to 28 Tex. Admin. Code 124.2(h) Notification to the Commission and the claimant of a dispute of disability, extent-of-injury, or eligibility of a claimant to receive death benefits shall be made as otherwise prescribed by this title and requires the carrier to use plain language notices with language and content prescribed by the Commission. These notices shall provide a full and complete statement describing the carrier's action and its reason(s) for such action. The statement must contain sufficient claim specific substantive information to enable the employee/legal beneficiary to understand the carrier's position or action taken on the claim. A generic statement that simply states the carrier's position with phrases such as 'no medical evidence to support disability,' 'not part of compensable injury,' 'liability is in question,' 'under investigation,' 'eligibility questioned' or other similar phrases with no further description of the factual basis for the action taken does not satisfy the requirements of this section." The respondent did not file a PLN11 disputing extent-of-injury for this claim.
2. Upon further review as indicated by the Division's database, the Division finds there are no unresolved extent-of-injury issues with this claim.
3. Documentation supports the services billed under 28 Tex. Admin. Code §133.210(c)(3).
4. The requestor, as a non-CARF accredited facility, is entitled to reimbursement in the amount of \$28,096.00 pursuant to 28 Tex. Admin. Code §134.202(e)(5).

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$28,096.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$28,096.00 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

Authorized Signature

Medical Fee Dispute Resolution Manager

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.